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The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues

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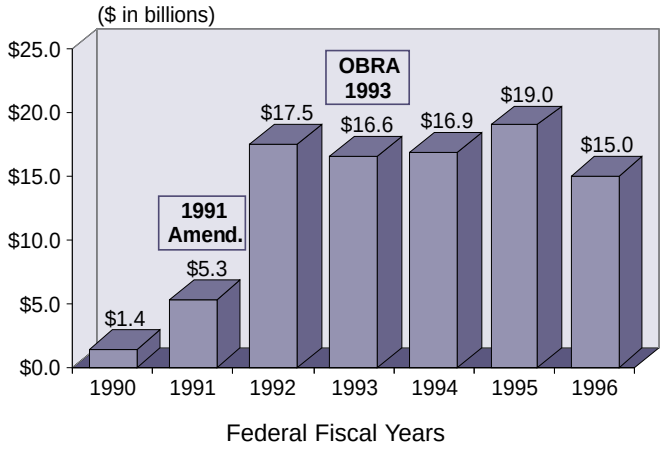
Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Expenditures for DSH have increased significantly in recent years: Between 1990 and 1996, for example, DSH payments grew from $1.4 billion to $15 billion (figure 1). By 1996, DSH payments accounted for 1 of every 11 (federal and state) dollars spent on Medicaid. Indeed, the increase in DSH payments was a major reason for the rapid growth in Medicaid expenditures in the early 1990s.

The Medicaid DSH program has sparked intense debate between the states and the federal government throughout the 1990s. The federal government has been strongly critical of some states' "abuse" of the DSH program, arguing that these states have used it to decrease their Medicaid fiscal responsibilities at the expense of the federal government. States, however, assert that the

Figure 1
Medicaid Disproportionate Share Hospital Spending 1990–1996



Source: HCFA 64 forms.

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DSH program is essential to maintaining the health care safety net for vulnerable populations. In addition, hospitals (especially public facilities) argue that DSH payments are critical to their survival. The DSH program continues to be a highly important and controversial policy issue. In the 1997 federal budget discussions the Medicaid DSH program was a key issue, and many changes to the program were enacted, including federal cutbacks.

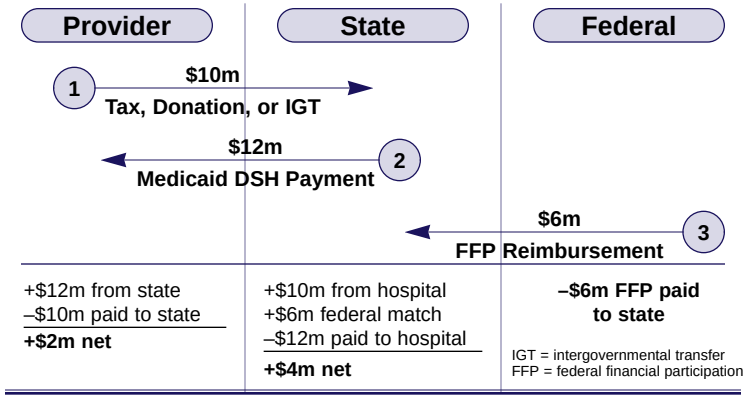
This policy brief describes the origins and evolution of the DSH program. We review some of the history of, and the controversies surrounding, the program during the early 1990s, when DSH expenditures first began to escalate. We also discuss federal DSH legislation enacted during that time period. We conclude with highlights of the federal DSH provisions included in the Balanced Budget Act of 1997.

The Medicaid DSH Program: An Overview

The DSH program has its roots in the development of the Boren Amendment as established in the Omnibus Budget Reconciliation Acts of 1980 and 1981. Among other things, these pieces of legislation—in an effort to maintain access to health care—mandated that states consider special payment needs for hospitals that serve a large portion of Medicaid and uninsured patients. The rationale behind the special payments was that hospitals rendering high volumes of care to low-income Americans often lost money as a result of low Medicaid reimbursement rates. They also lost money because these same hospitals generally provided high volumes of care to indigent patients and thus had high levels of uncompensated care. In addition, hospitals with large caseloads of low-income patients frequently had low private caseloads. Hence, they were less able to shift the cost of uncompensated care to privately insured patients.

Although the DSH mandate was legislated in the early 1980s, states were slow to act on it. By 1989, only a handful of states were making DSH payments. To encourage states to make Medicaid DSH payments, Congress passed several DSH provisions during the mid-1980s. A key provision—which was included in OBRA 1986—allowed states to pay hospitals rendering high volumes of care to low-income patients rates above those paid by Medicare and to exceed the so-called "Medicare upper payment limit."[1] This exception to the upper payment limit was central to the rapid growth of Medicaid DSH expenditures that began in the early 1990s.

Figure 2
How a DSH Program Can Work



Source: Urban Institute 1997.

Use of Provider Tax and Donation Programs

Also key to DSH expenditure growth was the development of provider tax and donation programs. In an effort to afford states greater flexibility in raising Medicaid funds, the Health Care Financing Administration (HCFA) issued a rule in 1985 that allowed states to receive donations from private medical care providers. West Virginia was the first state to use provider donations. Hit by a deep recession at the time, West Virginia did not have state funds to pay hospitals for Medicaid services and thus could not draw Medicaid federal financial participation (FFP) dollars. Hospitals in West Virginia helped the state out by "donating" money to the state which, in turn, paid the hospitals with the donated funds. The process of paying hospitals allowed the state to earn FFP dollars and draw federal matching funds without, in fact, having to spend state dollars. Also in the mid-1980s, some states adopted provider tax programs, which operated along the same principles as donation programs. Florida was the first state to establish a provider tax program, in 1984.

Provider tax and donation programs had enormous financial advantages for states. Each dollar of revenue raised from a tax or donation program could generate one to four FFP dollars, depending upon the state's federal matching rate. However, in order to earn FFP dollars, the state had to spend the tax or donation revenues because federal Medicaid matching payments are based on expenditures, not revenues. It was the Medicaid DSH payment that provided the mechanism to spend the tax and donation revenues. The DSH payment was singled out because—as discussed above—it was not subject to the Medicare upper payment limit. Thus, states could make virtually unlimited DSH payments and, in the process, earn FFP dollars.

How a Medicaid DSH Program Can Work: An Example

Figure 2 provides a hypothetical schematic of a DSH program in which the state relies on revenues from provider taxes, donations, or intergovernmental transfers (IGTs)[2] for the state share.[3] The schematic shows the link among revenue programs, the DSH payment, and federal reimbursement:

(1) Revenue: State receives revenue from a provider. In this example, the state receives $10 million.

(2) Spending: State then makes a DSH payment back to the provider as a lump sum payment or an increase in the Medicaid inpatient reimbursement rate. Here, the state makes a $12 million DSH payment to the same provider that made the donation. At this point in the transaction, the provider has received $2 million in DSH payments while the state is "out" $2 million.

(3) Federal Match: Since DSH payments are matchable Medicaid expenses, the federal government reimburses the state anywhere from 50 to 80 percent of the DSH payment, depending upon the state's federal Medicaid matching rate. In this example, the state matching rate is 50 percent, and the federal government reimburses the state half of the $12 million, or $6 million.

At the end of the transaction, the provider has received $2 million in DSH payments while the state has received $4 million in federal money without spending any of its own funds. The federal government has paid $6 million in DSH payments. However, only $2 million was channeled to the DSH provider; the balance was retained by the state.

Once states discovered they could leverage additional federal dollars in this way, many established provider tax and donation programs in the early 1990s. Between 1990 and 1992 the number of states with such programs grew from 6 to 39. DSH payments escalated accordingly, from $1.4 billion in 1990 to $17.5 billion in 1992 (figure 1). DSH spending accounted for 15 percent of total Medicaid spending in 1992, up from only 2 percent in 1990 (table 1). The extent to which states expanded their DSH programs in the early 1990s varied dramatically. In 1992, for example, DSH spending accounted for 35 percent of New Hampshire's spending and 43 percent of Louisiana's. By contrast, DSH accounted for less than 1 percent of many states' program spending, including Arkansas, Iowa, and Wisconsin.

Fiscal Pressures on the States

For states the ability to draw federal matching dollars through the DSH program came at a time when they needed fiscal relief. In 1991 the country was in economic recession and virtually every state was experiencing financial problems. Growth of state revenues was slow, and states were reluctant to raise taxes. At the same time, demand for social assistance, including Medicaid coverage, was rising. Beyond the impact of the recession, states were also feeling fiscal pressures in their Medicaid programs because of the many federal eligibility changes adopted in the late 1980s mandating expansions to pregnant women and children. Pressure to comply with the Boren Amendment—which, among other things, required states to pay Medicaid providers rates that are "reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities"—was also adding to the fiscal distress states were feeling in the early 1990s. In sum, federal DSH payments provided a much needed source of revenue for states.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

The rapid rise in Medicaid DSH payments, however, stirred substantial controversy among federal policymakers. To resolve the issue, an agreement was reached between the Bush administration and the National Governors' Association. Elements of that agreement were put into the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 101-234). Key provisions included:

- Essentially banning provider donations.
- Capping provider taxes so that provider tax revenues could not exceed 25 percent of the state's share of Medicaid expenditures.
- Imposing provider tax criteria so that taxes were "broad based" and providers were not "held harmless."
- Capping state DSH payments at roughly their 1992 levels. The law limited national DSH payments to 12 percent of total Medicaid costs. Those states whose DSH payments were 12 percent or more of total Medicaid expenditures ("high-DSH" states) in 1992 could not exceed this dollar level in the future. States whose DSH payments were less than 12 percent ("low-DSH" states) could increase them at the same rate as their overall Medicaid expenditure growth. (See table 1 for state DSH designation.)

The most important effect of the 1991 law was that it curtailed DSH payment growth (see figure 1). It also forced many states to fundamentally restructure the financing of their DSH programs. States that had relied on provider donations had to find another revenue source. Likewise, states that had relied on provider tax programs needed to revamp their programs to comply with the law. The broad-based and hold-harmless tax criteria caused considerable difficulties for many states. Before the 1991 law, providers were generally promised that they would receive DSH payments that at least equaled what they contributed in the form of taxes or donations. The new law, however, prohibited this: taxes had to be a "real" assessment. As a result, many states had trouble enacting provider taxes that complied with the 1991 law.

Development of Intergovernmental Transfer Programs

Because of these difficulties, many states turned to IGT programs as the revenue source for their DSH programs. As the name implies, intergovernmental transfers are fund exchanges among or between different levels of government. For example, a state transfer of money to a county to support primary education constitutes an IGT. For the DSH program, many states began to transfer funds from public institutions such as state psychiatric facilities, university hospitals, and county or metropolitan hospitals to the state Medicaid agency. Then the state would make DSH payments back to these hospitals, collecting FFP dollars in the process. By targeting DSH payments to public facilities, the IGT mechanism provided the added advantage (over provider tax and donation programs) of preserving federal DSH dollars for state and local institutions. Depending upon the specifics of a program, private hospitals could be completely excluded under an IGT-financed DSH program.

OBRA 1993 DSH Provisions

While the 1991 law controlled DSH spending growth, federal policymakers again became concerned about how the DSH program was

Table 1

Medicaid DSH Payments as a Percent of Total Medicaid Spending, Allotments, and High/Low DSH Status

	DSH as a Percent of Total Medicaid Spending			1995[a]		
	1990[a]	1991[a]	1992[a]	DSH as a Percent of Total Medicaid Spending	Allotment ($ in thousands)	High/Low Status[b]
Alabama	24.1%	14.6%	27.8%	21.4%	$ 417,458	High
Alaska	0.0	0.0	0.0	6.1	19,589	Low
Arizona	0.0	0.0	0.0	7.6	n/a	n/a
Arkansas	0.2	0.2	0.3	0.3	3,039	Low
California	0.2	1.2	19.9	19.3	2,191,451	High
Colorado	0.7	6.9	12.2	23.3	302,014	High
Connecticut	0.1	0.0	18.7	15.9	408,933	High
Delaware	0.0	0.0	0.0	2.1	5,924	Low
District of Columbia	0.0	0.0	5.5	6.3	41,039	Low
Florida	1.7	1.2	4.6	5.4	286,478	Low
Georgia	0.1	2.6	12.1	11.4	382,344	Low
Hawaii	0.0	0.8	12.8	0.1	64,078	Low
Idaho	0.0	0.0	0.5	1.2	1,985	Low
Illinois	2.6	3.1	7.3	6.9	394,993	Low
Indiana	0.3	1.1	8.5	15.8	336,799	Low
Iowa	0.3	0.3	0.5	0.4	5,497	Low
Kansas	7.0	8.8	23.6	7.8	188,935	High
Kentucky	0.0	11.8	14.4	10.2	264,289	Low
Louisiana	8.5	8.5	43.2	30.7	1,217,636	High
Maine	0.5	7.7	18.6	17.4	165,317	High
Maryland	0.0	0.0	6.0	6.5	129,543	Low
Massachusetts	0.0	23.6	10.7	10.9	567,128	Low
Michigan	2.1	8.1	14.4	8.6	617,700	Low
Minnesota	0.6	0.6	2.2	0.9	55,394	Low
Mississippi	0.4	2.9	14.1	12.0	158,464	Low
Missouri	4.4	29.7	31.2	26.4	731,894	High
Montana	0.1	0.1	0.0	0.1	1,300	Low
Nebraska	0.3	0.3	0.6	1.4	11,000	Low
Nevada	0.1	0.3	19.8	15.9	73,560	High
New Hampshire	0.0	13.0	35.4	38.7	392,006	High
New Jersey	1.5	7.2	26.2	23.9	1,094,113	High
New Mexico	0.3	0.0	2.3	0.9	15,757	Low
New York	3.4	5.5	17.3	12.4	2,831,864	Low
North Carolina	4.3	7.2	13.4	11.0	389,266	Low
North Dakota	0.0	0.0	0.0	0.4	1,155	Low
Ohio	1.7	1.8	9.4	10.3	566,925	Low
Oklahoma	0.5	1.4	2.1	1.6	23,568	Low
Oregon	0.8	1.1	2.2	2.0	25,058	Low
Pennsylvania	0.2	10.6	16.1	11.4	967,407	High
Rhode Island	0.0	13.0	10.4	17.2	94,432	Low
South Carolina	7.2	16.6	28.4	21.8	439,759	High
South Dakota	0.0	0.0	0.0	0.3	1,302	Low
Tennessee	6.4	10.6	17.6	0.0	430,611	High
Texas	0.2	4.9	24.2	17.4	1,513,029	High
Utah	0.3	0.8	1.1	0.8	5,514	Low
Vermont	0.0	0.7	9.4	11.1	26,662	Low
Virginia	0.6	1.1	9.5	7.1	185,746	Low
Washington	2.3	1.6	11.4	12.3	307,993	Low
West Virginia	0.0	0.0	8.8	2.0	121,883	Low
Wisconsin	0.1	0.2	0.4	0.5	10,881	Low
Wyoming	0.1	0.1	0.1	0.0	1,389	Low
Total	**2.0%**	**6.0%**	**15.4%**	**12.5%**	**$18,490,101**	

Source: Ku and Coughlin (1995) and HCFA 64 forms.

a. Federal fiscal years.

b. The high/low status does not match the 12 percent designation perfectly because at a later point 12 percent became a target rather than an absolute cutoff.

functioning. Specifically, they were concerned about how payments were being issued to individual providers. A particular worry was that some states were making DSH payments to medical facilities that were not large Medicaid providers while other states were making DSH payments that exceeded hospitals' financial losses in serving the Medicaid and uninsured populations. Some providers were even receiving DSH payments in excess of their total Medicaid revenue received for rendering care to Medicaid patients. In the view of federal policymakers, DSH payments were not fully being used for their intended purpose of helping safety net providers, but rather they were being used to help general state financing. Indeed, a 1993 survey of 39 state DSH programs found one-third of DSH funds were being retained by states rather than being paid to DSH hospitals (Ku and Coughlin, 1995).

To address these and other issues, Congress included several DSH provisions in OBRA 1993:

- Only those hospitals that had a Medicaid use rate of at least 1 percent could receive DSH payments.

- Total DSH payments to a single hospital could not exceed the unreimbursed costs of providing inpatient care to Medicaid patients (i.e., the Medicaid shortfall) and uninsured (e.g., charity care) patients.

These limits took effect in 1994 for most public hospitals and in 1995 for private hospitals.[4]

Post–OBRA 1993

At present states are changing their DSH programs to comply with the OBRA 1993 conditions. Under the new limits, though, some states are finding it difficult to spend their full DSH allotments as provided in the 1991 law. This is especially true for states with large DSH programs that were supported by IGTs and where payments were largely directed to public hospitals.

In addition to the 1993 limits, other factors are beginning to affect states' ability to fully spend their DSH payments. Most prominent is the increase in Medicaid managed care. Key to the success of managed care is shifting care from the inpatient to the outpatient setting. Such a move could significantly disrupt the flow of DSH funds, which are targeted expressly to inpatient care. Relatedly, as Medicaid beneficiaries are mainstreamed into private managed care plans and cared for in private hospitals, traditional safety net providers—historically the principal recipients of DSH payments—will experience a decrease in Medicaid revenues. They are also likely to experience a decline in DSH funding: As Medicaid patients are treated more and more in private facilities, DSH payments often follow the patient. Beyond the shift to managed care, the transition to a more competitive health care market will also affect the flow of DSH payments to safety net hospitals: As competition among payers increases, Medicaid reimbursement has become more attractive to hospitals that may have not historically sought out Medicaid patients.

While states have complied with the law, it has created financial hardship for some safety net hospitals and fiscal problems for a few states. Some states have responded by seeking alternative means to help fund their Medicaid programs. Many of the states seeking such help were ones that had large DSH programs and had become increasingly reliant on federal DSH funding to support their overall Medicaid program. Examples include:

- *1115 Waivers.* Tennessee obtained an 1115 waiver from HCFA allowing it to fold DSH payments into overall program spending, among other things. Los Angeles County, whose hospitals relied heavily on DSH funding, also used the waiver approach. The county secured additional federal funding to help support efforts to fundamentally restructure the county health system.

- *Federal legislation.* Both Louisiana and New Hampshire received special accommodations via federal legislation that enabled them to keep a greater share of federal funds than would otherwise have been possible following passage of OBRA 1993.

- *1915(b) Waivers.* Alabama established a network of Prepaid Health Plans (PHPs) to act as an intermediary between the hospitals and the state Medicaid agency. In short, DSH payments are folded into the capitation rates paid to the PHPs, which pay hospitals for services rendered. By including DSH payments as part of the cap rates, the provider-specific limits imposed by OBRA 1993 were avoided. The 1915(b) waiver was necessary to require enrollment of Medicaid beneficiaries into the PHPs.

The 1997 Federal Budget Debate

Federal policymakers have set the goal of a balanced budget by 2002 as negotiated in the Balanced Budget Act of 1997 (P.L. 105-33). To achieve this, several expenditure cuts were made. For the Medicaid program, the prime budget target was the DSH program.

Policymakers singled out DSH payments because they believed that the payments have sometimes not gone to help safety net providers but instead have provided fiscal relief for states' budgets. Moreover, policymakers have argued that the distribution of federal DSH payments among states is not sound, largely because of the way the program developed in the early part of the decade. For example, federal Medicaid DSH payments per poor person (under 150 percent of poverty) in 1995 ranged from virtually zero in some states to over $1,500 in others.

During the 1997 budget debate, Congress and the Clinton administration put forward several proposals aimed at reforming the Medicaid DSH program. While the specifics of each proposal varied, all sought to reduce federal DSH payments. The final DSH provisions included in the Balanced Budget Act call for a number of changes to the DSH program. The key ones:

- Establishing new state-specific DSH allotments for each year in the 1998 to 2002 time period, thereby eliminating the allotments

established in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments passed in 1991. After 2002, federal DSH expenditures are allowed to increase by the percentage change in the Consumer Price Index, subject to a ceiling of 12 percent of each state's total annual Medicaid expenditures.

- Limiting how much of a state's federal DSH allotment can be paid to institutions for mental diseases (IMDs) or long-term mental hospitals. By 2002, no more than 33 percent of a state's federal DSH allotment can be paid to IMDs.

- For DSH payments made on behalf of Medicaid clients enrolled in managed care, payments must be paid directly to hospitals rather than managed care organizations.[5] Thus, DSH payments are not to be included in capitation rates.

To assess how the new federal DSH allotments are likely to affect states, we conducted a simulation analysis. The results are provided in table 2. The first two columns of the table show reductions in federal DSH spending from 1998 to 2002 likely to result from the new law relative to 1995 DSH spending levels.[6] (We assumed that, in the absence of the new law, no growth in DSH spending over 1995 levels would have occurred between 1998 and 2002.) The third and fourth columns show likely reductions in DSH spending in 2002 under the new law relative to actual 1995 DSH spending.

Assuming no growth in DSH spending likely underestimates what increases would have been under previous law, and therefore probably also underestimates the extent of the saving realized under the new provisions. This is particularly true for low-DSH states that had been allowed to increase their DSH spending under the old law. However, given that DSH spending trends have been somewhat volatile in recent years, we felt that postulating no growth in DSH spending over 1995 levels as plausible as any other specific assumption.[7]

Based on our simulations, we estimate that federal spending on Medicaid DSH will be about $5.8 billion less over the 1998 to 2002 period than it would have been otherwise. Nationally, this represents an 11 percent decrease in spending. As can be seen, the estimated impact of the provisions varies greatly from state to state. Many states with low shares of DSH spending (for example, Minnesota and Oregon) will experience no cuts in their federal DSH payments relative to 1995 spending levels. By contrast, some states were estimated to experience very large cuts. Colorado, for example, was estimated to see a 57 percent drop in federal DSH spending over the time period whereas Indiana was predicted to see a 25 percent drop.

Conclusion

For many states, the Balanced Budget Act of 1997 calls for a major restructuring of their DSH programs. The act also represents a significant cutback in federal Medicaid dollars that were targeted to provide financial relief to safety net providers. This cutback comes at a time when safety net hospitals are facing other Medicaid and market changes that have affected their revenues, such as the growth in Medicaid managed care or cuts in the Medicare program. State policymakers will need to make some key decisions about how they are going to handle the DSH reductions. For example, states may opt to fill the DSH cutbacks with state dollars. Alternatively, they may decide to alter how they distribute their DSH dollars to hospitals. With over 35 million uninsured Americans, the need to support safety net providers is profound. Thus, the DSH provisions included in the Balanced Budget Act pose new challenges for many states as they look for ways to provide health care services to the low-income population.

Notes

1. In 1983 HCFA issued a regulation stating that states could not pay more in the aggregate for Medicaid inpatient care or long-term care services than what would have been paid under the Medicare program. This is commonly referred to as the "Medicare upper payment limit."

2. For DSH purposes, intergovernmental transfer programs function like provider tax and donation programs. Around 1992 many states started to use IGTs in lieu of provider tax and donation programs (see section on "Development of Intergovernmental Transfer Programs").

3. It is important to note that not all DSH programs rely on revenue generated from provider taxes, donations, or IGTs. A 1993 survey revealed that many states—for example, Alaska, Oregon, and Wisconsin—fund their DSH payments with state general fund dollars just like other Medicaid services (Ku and Coughlin, 1995).

4. Some exceptions to the implementation deadlines were included. For example, public hospitals that were determined to be "high-DSH" hospitals were permitted to receive payments up to 200 percent of the unreimbursed costs of their Medicaid and uninsured patients for a one-year period.

5. This particular provision does not apply to DSH payments that were being paid directly to managed care organizations as of July 1, 1997.

6. In conducting the simulations we also considered the new caps to be binding only if they were below a state's 1995 DSH level, our assumed baseline spending level. Because of this assumption, some states do not experience any reduction in DSH spending under the new law. It should be noted that the simulations do not account for the possibility that some states may not—or may not be able to—fully spend the new DSH allotments.

7. Of course, other assumptions about what spending growth would have been without the new provisions would change the results. The Congressional Budget Office, for example, assumed in its impact analysis of the new provisions that DSH spending would have grown 7.7 percent each year between 1998 and 2002 under the old law. Using this assumption, CBO reported a $10.4 billion reduction in federal DSH spending over the 1998–2002 period. The $10.4 billion figure, however, assumes that 25 percent of federal DSH savings as specified in the new provisions would not be realized because states would make up some of the DSH savings by spending more in other parts of their Medicaid program (Congressional Budget Office, August 12, 1997).

Table 2

Simulated Impact of Balanced Budget Act of 1997 on Federal DSH Spending, 1998–2002

	1998–2002 Reduction Relative to 1995 Spending Levels[a, b] ($ in millions)		2002 Reduction Relative to 1995 Spending Levels[a] ($ in millions)	
	Difference[c]	Percent Change	Difference[c]	Percent Change
Alabama	$ (168)	-11%	$ (48)	-16%
Alaska	(<1)	-1	(<1)	-2
Arizona	n/a	n/a	n/a	n/a
Arkansas	(2)	-16	(<1)	-16
California	(461)	-9	(204)	-19
Colorado	(537)	-57	(114)	-61
Connecticut	(248)	-22	(65)	-29
Delaware	—	0	—	0
District of Columbia	(11)	-8	(2)	-8
Florida	(28)	-3	(28)	-15
Georgia	(89)	-7	(40)	-16
Hawaii	n/a	n/a	n/a	n/a
Idaho	(9)	-64	(2)	-64
Illinois	(83)	-8	(34)	-17
Indiana	(314)	-25	(80)	-32
Iowa	—	0	—	0
Kansas	(19)	-9	(10)	-24
Kentucky	(125)	-16	(37)	-24
Louisiana	(919)	-20	(288)	-31
Maine	(69)	-13	(21)	-20
Maryland	(66)	-16	(19)	-24
Massachusetts	(178)	-12	(61)	-20
Michigan	(79)	-6	(37)	-15
Minnesota	—	0	—	0
Mississippi	(46)	-6	(21)	-15
Missouri	(186)	-9	(57)	-13
Montana	—	0	—	0
Nebraska	(2)	-7	(<1)	-7
Nevada	—	0	—	0
New Hampshire	(155)	-19	(34)	-21
New Jersey	(489)	-15	(128)	-20
New Mexico	—	0	—	0
New York	(293)	-4	(173)	-12
North Carolina	(89)	-6	(42)	-15
North Dakota	—	0	—	0
Ohio	(125)	-7	(58)	-15
Oklahoma	—	0	—	0
Oregon	—	0	—	0
Pennsylvania	—	0	—	0
Rhode Island	(189)	-40	(43)	-45
South Carolina	(156)	-10	(49)	-16
South Dakota	—	0	—	0
Tennessee	n/a	n/a	n/a	n/a
Texas	(546)	-11	(193)	-20
Utah	(2)	-10	(<1)	-10
Vermont	(23)	-21	(5)	-21
Virginia	(37)	-10	(14)	-19
Washington	(88)	-10	(33)	-18
West Virginia	—	0	—	0
Wisconsin	—	0	—	0
Wyoming	—	0	—	0
Total	**$ (5,833)**	**-11%**	**$ (1,943)**	**-19%**

Source: Urban Institute calculations from HCFA 64 forms.
a. Federal fiscal years.
b. CBO estimates a total savings of $10.1 billion over the same period since the CBO DSH baseline assumes average annual spending growth of 7.7 percent per year under the old law. By comparing the effects to 1995 DSH spending, we are in effect assuming no growth in DSH, which results in lower estimated savings.
c. Differences assume that new allotments are only binding if they are below assumed spending for each year.

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